STATE OF DELAWARE
The Department of Services for
Children, Youth and Their Families

DIVISION OF CHILD MENTAL HEALTH SERVICES

PROVIDER MANUAL

Revised August 2008

THIS MANUAL CONTAINS CRITICAL INFORMATION FOR SUCCESSFUL DCMHS/PROVIDER RELATIONS AND IS ATTACHED BY REFERENCE TO THE DCMHS CONTRACT.

Please make this manual (or its relevant sections) available
To staff who are responsible for the following key functions:

- *Obtaining Authorization*
- *Contract Compliance*
- *Clinical Standards and Quality Improvement*
- *Billing and Records Management*

Note: This manual and much of the information referred throughout can be viewed via the CMH internet site.
http://kids.delaware.gov/cmhs/cmhs_providers.shtml

Table of Contents

Introduction ..... Section I

Division overview 1

This document 1

Accreditation 2

Accreditation requirement 2

Provider Services Network ..... Section II

Care assurance 1

Membership 1

Network providers 1

Out-of-Network providers 1

Contracting and reimbursement methods 1

Service System Administrators 2

Referral/Application for Services ..... Section III

Client eligibility 1

Access 1

Request for change in level of service or for additional services 2

MCO referral 2

Medicaid transportation 2

Clinical Services Management ..... Section IV

CSM team 1

Clinical criteria 1

Authorization process 1

All CMH services (other than outpatient) 1

Outpatient services 2

Treatment Protocol ..... Section V
Client education: Written information provided to clients and families 1
Consent to treat 2
Initial diagnostic evaluation 2
Integrated assessment 3
Comprehensive treatment plan 4
Treatment plan review 5
Progress notes 5
Discharge 5
Cllinical Record Retention 6

Client Safety and Outcome ..... Section VI
Clinical Program – Staffing and Supervision 1
Performance improvement 2
Outcome measurement 2
Client rights and responsibilities 2
Confidentiality 3
Complaints 3
Risk Management 3
Risk management system 3
After hours clinical emergencies 3
Critical Incidents 4
General requirements 4
Alleged child abuse 4
Environment and Milieu 4
Emergency preparedness 4
Smoking 5
Hazardous materials 5
Medication 5
Medical Expenses 5
Behavior management 5
Program review 5

Document Deliverables..... Section VII
Clinical information and reports.....1
Client safety documents.....1
Credentialing.....1
Schedules of document deliverables.....2
Clinical information - All services except outpatient.....2
Clinical information - Outpatient.....3
Adminsitrative informatin.....3

Reimbursement .....Section VIII
Submission of hard copy Billing 1
Program funded contracts 1
Unit cost contracts 1
Outpatient.....1
All other unit-cost contracts.....1
Submission of electronic billing 1
Direct deposit….. 2

Feedback and suggestions..... Section IX

I. INTRODUCTION

A. Overview - The Division of Child Mental Health Services (CMH)

1. Mission - To provide accessible, effective treatment services for children through collaboration with families and service partners.

   Vision - Children and families: reaching their fullest potential.

2. CMH provides services to children and families in accordance with the core values and principles of a Systems of Care approach:

   a) Values - child-centered and family focused with the needs of the child and family dictating the types and mix of services provided; community-based services, integrated with intensive care management; culturally competent, with services that are responsive to the cultural, racial and ethnic differences of the population served.

   b) Guiding Principles - comprehensive service array to meet individual child and family needs; individualized service planning; least restrictive, most normative setting which is clinically appropriate; families and surrogate families should be full participants in all aspects of the planning and delivery of services; intensive care management to ensure coordination and integration of services; early identification and intervention for children with emotional disturbances; smooth transitions to adult services at age 18; rights of children and their families should be protected and effective advocacy for children with emotional disturbances should be promoted.

3. Legislated Mandate - In 1983, 29 Delaware Code, Chapter 90 established the Department of Services for Children, Youth and Their Families (DSCYF). DSCYF is made up of four divisions which focus on specific child and family needs. Each has a legal mandate to provide certain aspects of treatment/intervention for children and families involved with the Department:

   a) The Division of Family Services (DFS) provides intervention services for abused, neglected, and dependent children and adolescents and their families.

   b) The Division of Youth Rehabilitative Services (DYRS) provides treatment/habilitation/rehabilitation for youth, both pre and post adjudication.

   c) The Division of Management Support Services (DMSS) provides fiscal, personnel and other general services for the Department. DMSS is also responsible for coordinating and/or providing education services for residential and day treatment programs.

   d) The Division of Child Mental Health Services (CMH) is mandated to provide a comprehensive continuum of treatment services for mentally ill, emotionally disturbed and substance abusing children, youth with their families in the least restrictive and most community-based service appropriate.

B. Commitment to Evidence-Based Practices

- CMH encourages treatment services which can be empirically supported in mental health and substance abuse literature for specific target populations and presenting problems. These practices may include, but not necessarily be limited to: positive behavioral interventions, cognitive behavioral therapy, multisystemic therapy, Cannabis Youth Treatment (CYT), etc.

C. This Document

- This document is a supplement to the Department of Services for Children Youth and Their Families Operating Guidelines for Service Providers, which sets forth the minimum standards expected for DSCYF providers.

  It specifies additional performance standards and expectations for CMH Providers. These are in addition to but not in lieu of other certifications, licensures, and State or Federal requirements.

CMH policies specifically referenced can be found on the CMH website and hard copies are available upon request.

D. Accreditation - CMH seeks to provide high quality services to children and families. To that end, CMH maintains accreditation by the Commission of Accreditation of Rehabilitation Facilities (CARF) under Business and Services Management Network Standards. CMH seeks to contract with providers who maintain their own accreditation through JCAHO, COA, CHAP or CARF (See below.)

1. Providers with accreditation: CMH accepts accreditation by the following bodies:
    - Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
    - Council on Accreditation (COA)
    - Commission on Accreditation of Rehabilitation Facilities (CARF)
    - Community Health Accreditation Program (CHAP).

2. Providers without accreditation status: At minimum, these providers must meet CMH clinical standards outlined in this manual and the Commission on Accreditation of Rehabilitation Facilities (CARF) standards for unaccredited providers under the Business and Services Management Network.
    - Unaccredited providers who were active with CMH on January 31, 2007 and have an annual contract of $200,000 or more must obtain their own independent accreditation by January 31, 2010.
    - New unaccredited providers who have an annual contract of $200,000 or more will be required in the Request for Proposals to demonstatre a plan to have their own independent accreditation within one year of start-up.

3. Accreditation and licensure certificates must be prominently displayed at each organizational site, and changes in accreditation status must be brought to the attention of the appropriate CMH System Administrator(s) within 24 hours.

E. Acknowledgment of public funding – If a contracted provider's name appears on the public information brochure published by the Division or the CMH website, the provider will include the following on all public relations documents: 'Member of the Division of Child Mental Health Service System.'

II. PROVIDER SERVICES NETWORK

A. CMH Care Assurance - CMH acts as a public Managed Care Organization (MCO) for children's behavioral health treatment. It provides mental health and substance abuse treatment and case management to eligible children without limit for as long as it is clinically necessary.

1. CMH Client Population: Children and adolescents, who are residents of the State of Delaware, are under age 18 and are Medicaid-eligible or who are without insurance coverage. All services are voluntary in that they require consent of the parent or legal guardian. The only exception is for involuntary psychiatric hospitalization.

2. CMH Role in Delaware Medicaid Managed Care: Medicaid Managed Care in Delaware is called the *Diamond State Health Plan (DSHP).* For behavioral health care there is a public/private partnership to ensure that children with Medicaid get the care that is clinically necessary. The DSHP-contracted MCOs provide the basic health care benefit as well as the basic annual behavioral health care benefit of up to 30 hours of outpatient mental health or substance abuse services. CMH provides extended services under the DSHP, i.e. services beyond the 30 hours per year of outpatient behavioral healthcare that is included in the basic benefit package provided by the contracted MCOs. Instruction for how MCO providers can access supplementary funding for their outpatient clients is on the CMH Website. (Click on Providers)

B. Membership in the Provider Network

The DCMHS website has instructions for how to become a provider.

1. Network Providers: CMH provides services through a contracted panel of agencies and individuals. Although CMH prefers to contract with Providers who deliver services within the state, out-of-state contracts are negotiated for residential services not available in Delaware.

2. Out-of-Network Providers: CMH negotiates contracts/agreements for services not ordinarily available from an established CMH provider. These specialties include but are not necessarily limited to: eating disorders, complicated medical non-compliance, services provided in languages other than English including American Sign Language (ASL).

C. Contracting and Reimbursement Methods

1. Cost-Reimbursable Contracts – These are services in which CMH fully funds a program using a line-item budget. These contracts may be used only in specific circumstances prescribed by the Department.

2. Unit Cost Services – These contracts are funded on a fee for service basis.

D. CMH Administrators

1. Each service provider is assigned a primary CMH system administrator who is responsible for the program, for provider relations and for contract management.

2. The names of system administrators can be found on the CMH website (click on Providers.).

III. REFERRAL/APPLICATION FOR SERVICES

A. CMH Client Eligibility - CMH provides mental health and substance abuse services to children under age 18, who are Medicaid-eligible, or who are without insurance coverage; who are residents of the State of Delaware and who meet the CMH criteria for treatment at specific levels of care (NOTE: For further information see the CMH Eligibility Policy [CS 001] and "clinical criteria" available on the CMH web site).

B. CMH Eligibility for Non-Residents of the State of Delaware - Crisis services and short-term emergency hospitalization may be provided to non-resident youth under the age of eighteen who are in Delaware and whose behaviors present imminent danger to self or others due to behavioral health disorders. CMH reserves the right to seek reimbursement for services provided to non-Delaware residents.

C. Access - There are three points at which a client may be admitted to the Division of Child Mental Health System:

1. *Outpatient Services* - Parents/caretakers may call any of the CMH mental health or substance abuse outpatient providers listed in the CMH information brochure. These providers will assess clinical and financial eligibility and assist clients and their families to obtain appropriate care. Brochures are available at (302) 633-2571 and is on the CMH Website.

2. *Central Intake* - For information and referral. To obtain services in non-emergency situations other than outpatient services, an application must be received through central intake, information and referral.

   ⇒ CMH Central Intake, Information and Referral: (302) 633-2571 or (302) 633-2591

   ⇒ or Toll-Free 1-800-722-7710

3. *Crisis Services* - CMH offers 24-hour, 7 day a week crisis response for children or adolescents who are exhibiting behaviors that pose a serious and immediate danger to him/herself or others due to emotional disturbance, substance abuse or mental illness, e.g., suicidal attempts or threats, command hallucinations, aggressive behavior. This program also responds to children in crisis who may have experienced recent and severe trauma, e.g. witness to a suicide, etc.

   IMPORTANT: If the child is physically injured, seek medical attention first before calling the crisis number. If the behavior poses serious threats to self or others because of weapons or the inability to contain the situation without assistance, call the police before calling the crisis number.

   ⇒ Northern New Castle County (302) 633-5128

   ⇒ Southern New Castle County (south of the C&D Canal) 1-800-969-HELP

   ⇒ Kent and Sussex Counties (302) 424-HELP

   If the child has been physically abused or neglected call the Division of Family Services Hotline: 1-800-292-9582

D. If the provider operates a fully-funded program via a cost-reimbursable contract, the provider will work with the Department's referral sources to admit referred clients to the program in a prompt and efficient manner in order to maximize utilization of the program. Both parties to the contract appreciate the need to make maximally effective use of the resources committed by the Department to this program, and commit to a utilization target of 85% of capacity. Both parties agree to monitor program utilization against this target, and to work to identify and remove any procedural impediments to the efficient admission of clients to the program.

E. Requests for Change in Level of Service or Additional Services - Providers who are treating children/adolescents in a CMH service may request a change in level of care (i.e. from outpatient to intensive outpatient) by contacting the Clinical Services Management Team (CSMT) member assigned to the case. When making the request for a different level of care, the provider should be prepared to conduct a clinical review with the CSMT member. When appropriate, the CSM Team may request to review the revised treatment plan, e.g. if a wrap-around aide is being requested the treatment plan should reflect how the aide will be incorporated into treatment.

F. MCO Referral - If you are an MCO Provider seeking CMH services for your client:

1. For extended outpatient benefits (beyond the 30-unit MCO limit – call either CMH Administrators Mary Moor (633-2641) or Vanessa Bennifield (633-2597)

2. For a more intensive level of care call the CMH Intake number; 633-2571

G. Delaware Medical Assistance Program (Medicaid) - For information on how to apply to join the respective panels for the Medicaid Managed Care organizations, to obtain information about applying for Medicaid, etc can be found on the Internet at http://www.dmap.state.de.us/home/index.html.

H. LogistiCare is the transportation provider for Delaware Medicaid. Delaware Medicaid recipients can reach LogistiCare by calling 1-866-412-3778. Case Managers at facilities wishing to schedule medical transportation appointments for their clients may call 1-866-469-2824. If you have problems with your transportation services, please contact LogistiCare at 1-866-896-7211.

IV. CLINICAL SERVICES MANAGEMENT - With the exception of routine outpatient and crisis services, each child and family is assigned to a Clinical Services Management Team (CSMT), with a specific Clinical Service Coordinator (CSC) who will work with them until the child is discharged from the system.

A. Clinical Services Management Team Responsibility:

1. In collaboration with client, family and providers, the CSMT plans services, determines the most appropriate level of service and works with the family to design an individual service plan for the child.

2. In collaboration with service providers, the CSMT authorizes initial admission and continued stay. This process includes the forwarding of a Service Admission Form (SAF) to the provider that gives information regarding goals of the service, issues to be addressed in the treatment plan and risk and safety issues that should be noted.

3. Monitors and evaluates individual client progress in treatment and re-authorizes continued treatment as clinically indicated.

4. Coordinates service provision, including service admission and discharge from CMH. The team also facilitates transitions across levels and providers of service (e.g., hospital to day treatment to outpatient) to assure continuity of care.

5. Provides clinical consultation as appropriate to providers on complex cases and/or cases where treatment progress is slow or minimal.

B. Clinical Criteria - All CMH services are authorized by CMH clinical services management teams, using established criteria for each level of care.

⇒ Written copy of clinical criteria is available on the CMH web site or upon request from the Director, Clinical Services Management (302) 633-2595.

C. Authorization Process

1. Authorization Process For CMH Services Other Than Routine Outpatient Services

a) Initial Authorization by CMH

(1) Process

(a) The CMH Data Unit Provider Liaison will call the named agency business contact to verify that service for a child has been authorized by CMH. Written notice of this authorization will be provided.

(b) The Provider must call CMH Data Unit within 24 hours (or the next working day) or the identified CSMT to notify CMH of the client's admission. CMH Data Unit will provide an authorization number for use in the billing process. (If admissions are not entered into the DSCYF data system, payment cannot be made.)

⇒ Data Unit Provider Liaison: (302) 892-6418

(2) Retroactivity - Retroactive authorization and/or payment will not be made. Providers are responsible to submit appropriate documentation within sufficient time-frames for the authorization process to be completed. Unauthorized services will not be reimbursed.

(3) JCAHO Accredited Hospitals - The initial authorization of a client for JCAHO accredited hospitals is contingent on the provider's timely submission of a provider Certificate of Need on the approved CMH form. See Schedule of Deliverables in this manual.

b) Authorization of Continued Treatment - If treatment is to continue beyond the authorization period, a Progress Review must be conducted between the provider and CMH.

(1) Progress Review - Prior to the end of the authorization period, a member of the CSM team will call the provider and conduct a telephone progress review. The telephone review will be based on the CMH Progress Review form. NOTE: Active provider participation is essential to assure timely reauthorization and collection of all data necessary to evaluate client progress.

⇒ IMPORTANT - If the pertinent provider representative is not available when the CSM team member calls, it is the provider's responsibility to return the progress review call in a timely fashion. If the CSM team member is not available when the provider returns the call, the Provider should dial "O" and have CMH staff page the CSM team member. This procedure specifically includes CSM team leaders. CMH aim in using this procedure is to increase accessibility to providers.

(2) Authorization - The CMH clinical services management team member will give verbal or faxed authorization at the time of the telephone review and authorization will be confirmed by the CMH Data Unit Provider Liaison who will contact the provider to notify of the reauthorization.

⇒ Data Unit Provider Liaison: (302) 892-6418

c) Client Discharge - All discharges of youth funded by DCMHS must be authorized by CMH in advance of the actual discharge, and coordinated with CMH in order to allow for a therapeutic transition of each youth to another level of care.

(1) When discharge of a client from a CMH service is anticipated, all parties, including the provider, the CSMT member and the parents must try to reach mutual agreement about the discharge, the after-care plan and activities. Confirmation of a discharge date should be done together. Services after this date are not authorized and the provider will not be reimbursed for them.

(2) At the time of discharge, the provider shall, if the client is on medication, ensure that the client is given a record of all current medications including dosage and administration. The documents shall be made available at the time of discharge to the parent or legal guardian, CMH and appropriate receiving agencies and personnel.

2. Authorization Process For Routine Outpatient Services - The process outlined below pertains only to outpatient providers. CMH intends that services at the outpatient level be as accessible as possible.

Unlike insurance companies, CMH outpatient clients are often not already registered as clients. That means outpatient providers must gather registration information such as financial eligibility in addition to clinical information.

- If providers receive the referral and authorization directly from a CMH clinical management team, it is unnecessary to complete the initial documents listed below.
- For all other cases, authorization and subsequent payment will not be made unless the following process is used:

a) Initial Authorization

(1) Eligibility - When Providers receive a request for CMH services, they will complete two assessments:

(a) Clinical Eligibility - CMH EPSDT Screen (available on the CMH website)

(b) Financial Eligibility Determination – Clients who are uninsured, do not have Medicaid, or whose insurance co-payment can be documented as being beyond their means to pay. In the latter case, CMH will authorize only the difference between the co-payment plus a reasonable sliding scale fee and the hourly rate contracted with the provider by the insurance company. This must, of course, be consistent with individual provider agreements with insurance providers.

(2) Submit a completed Admission to Outpatient Mental Health Services *or* Admission to Outpatient Substance Abuse Services Form. These forms and directions can be found on the CMH Website. *Complete* means that the form is legible and that every line has a response.

- In certain sections under Financial Eligibility, "NA" (Not Applicable) may be entered. Otherwise, all information must be completed.
- There must be a Primary Diagnosis other than "deferred."
- The parent/legal guardian must sign the form.

⇒ CMH Outpatient FAX Number: (302) 633-5146

(3) Initial Authorization - If clinical and financial eligibility is confirmed by CMH, initial authorization will be faxed back to the agency.

Initial authorization will be 20 sessions in one year (from the date of admission).

Although CMH authorization is not required prior to the first session, if initial authorization is denied, the first session and subsequent sessions held prior to authorization will not be reimbursed.

Retroactive authorization will not be made. Therapists are responsible to submit appropriate documentation within sufficient time-frames for the authorization process to be completed. Unauthorized services will not be reimbursed.

b) Request for Re-authorization (after 20 sessions or one year)

(1) If the client is to continue to receive services beyond 20 sessions in one year, the provider will submit:

(a) Revised Treatment Plan that includes at minimum, the problems that will be addressed and measurable objectives. If progress has not been made within the last authorization period, a plan must be included for how treatment will be changed in order to move toward the treatment goal. The treatment plan will be signed by the therapist (and the supervisor if the therapist is not licensed), the parent or guardian of the child, and the child (unless the latter can be demonstrated to be counter-therapeutic or developmentally inappropriate, e.g., child is under 5 years old.)

NOTE: All treatment plans that include medication as part of the treatment to be provided must be reviewed and signed by the treating psychiatrist.

(b) Request for Re-Authorization - Can be found on the CMH Website.

(2) If the treatment plan and form are fully completed, legible, and clinically appropriate, CMH will fax authorization of up to an additional 20 hours of service which may be provided within the same 12-month period of initial authorization.

CMH Outpatient FAX Number: (302) 633-5146

(3) Discharge Form - This form will be sent immediately after a planned discharge, and in no more than 90 days of the last face-to-face contact with the client after documented assertive follow-up in the case of unplanned discharge. (Failure to submit this form in a timely fashion could result in delay of payment of subsequent bills to the contractor). The Discharge Form and directions can be found on the CMH Website

⇒ Questions regarding client authorization will be handled by Sharon Jenkins at (302) 892-6437.

⇒ Questions from program directors about contractual matters will be handled by Mary Moor at (302) 633-2641.

V. TREATMENT PROTOCOL

A. Client Information/Education: Written Information Provided to Clients and Families – Upon admission, providers will meet with clients and families to discuss rights, responsibilities, procedures and expectations. Providers will have a system for documenting client and family receipt of such information, e.g. progress note, client/family signature, etc. This information will include, but not necessarily limited to, the following:

1. General service orientation, including the names and numbers of primary contacts
2. Client complaint/grievance procedures
3. Client rights and responsibilities
4. Prevention resource information
5. Emergency procedures
   a.) Residential and hospital providers will include any applicable seclusion/restraint procedures.
   b.) Nonresidential providers will inform caretakers as to how to reach the therapist in an emergency and will assure that caretakers are informed of the CMH crisis numbers.
   c.) Nonresidential substance abuse treatment providers will inform primary caretakers about the potential dangers and signs of alcohol and/or drug overdose and how to obtain medical treatment.
6. For crisis and routine outpatient services, providers review with clients and families, and provide a copy of the CMH Child/Family Entering Care Handbook for that level of service. The signed form indicating the client has received this document must be contained in the client record. These documents are on the CMH website. The CSMT provides copies to clients and families in other levels of care.
7. If a client is open for more than one year in any treatment episode, documentation that that clients have been re-informed of their rights, the complaint procedure and emergency procedures must appear in the client record.

B. Consent to Treat -The Provider will have written policies and procedures to assure that no minor will be treated without documentation of informed written consent to treat, signed by at least one parent or a person having legal authority to consent to treatment and witnessed by a representative of the provider. This consent must be renewable after one year. In certain cases, consent to treat may be signed by someone other than the parent or legal guardian.

1. If a youth is prescribed psychotropic medication, the provider shall ensure that written informed consent is obtained from the parent, legal guardian or other individual with legal authority to make such decisions, prior to the implementation of said medication regime. At a minimum, such informed consent shall indicate the drug and dosage, likely benefits, potential risks and side effects of said medication. Such informed consent shall also inform, to the extent permitted by law, the youth, their parents, legal guardians and other individuals with legal authority to give such consent, of their right to refuse specific medication or treatment procedures (see applicable Delacare Requirements for Residential Child Care Facilities, § 213; Delacare Requirements for Day Treatment Programs 215(e);16 Del. C. 5161(b)(3),(5)); DFS policies # 3045, 3046, 3047).
2. *Delaware's Relative Caregiver statute* allows relative caregivers to consent to lawful medical treatment for minors if the relative caregiver is in possession of a valid affidavit of establishment of power to consent to medical treatment. For further information please see: http://www.dhss.delaware.gov/dhss/dsaapd/intergen.html.
3. In mental health emergencies when a minor is exhibiting behaviors of such severity that failure to provide an immediate mental status examination and follow-up would result in

imminent harm to the child, evaluations may be performed by the CMH Crisis Services without initial written parental consent, if reasonable efforts have been documented to contact parents, legal guardians or other legally authorized caregivers. All follow-up treatment provided by crisis services must be with the appropriate signed consent-to-treat.

4. A representative of the Division of Family Services (DFS) may sign consent to treat in all levels of CMH services with the exception of psychiatric hospital if the client is in the custody of DFS, the parent is lost to contact and reasonable effort has been documented to notify the parent, legal guardian or legally authorized caregiver that the child has been admitted to those services.

5. Youth ages 14 and older may sign consent for treatment for alcohol or drug addiction without parental consent. CMH highly recommends that every effort be made to work with such a youth to involve parents as soon as possible in the treatment process.

C. Initial Diagnostic Evaluation - The provider shall perform a strength-based diagnostic evaluation appropriate to the level of care:

1. Crisis assessment - minimum required content is outlined in the crisis contract

2. Wrap-around assessments are done in conjunction with the assessment performed at the treatment agency.

3. Substance abuse programs will use the assessment instrument prescribed by CMH. (Currently Global Assessment of Need/GAIN)

4. The admission assessment will include documentation that the evaluator has covered (asked), at minimum, the following elements:

a) *Presenting Problem* - This element is the reason the client was referred for treatment and will include the frequency, duration and intensity of the problem. For referrals from CMH Clinical Services Management Teams (CSMT), this will include the information provided on the CMH Service Admission Form (SAF).

b) *Mental Status Examination* - This element includes a developmentally appropriate assessment of thinking and cognition, affective states and orientation, estimate of intellectual functioning, and includes routine questions about current and past suicidal or homicidal gestures, threats, attempts, etc. If the mental status examination is positive for suicidal ideation and/or other imminent issues of risk, documented follow-up assessment must include level of dangerousness.

c) *Functional Assessment* - This element is a review of how the client is currently functioning in school (academically, socially and behaviorally), at home and in the community. Collateral contact with the school (with appropriate release) is necessary unless the client is not enrolled in school or the appropriate signatory refuses to sign a release.

d) *Family Assessment* - This element includes a review of the family composition, home environment and family dynamics, including present family stressors and strengths.

e) *Developmental History* - This element includes a review of pre- and post-natal information, achievement of developmental milestones, and early medical history.

f) *Physical Health Assessment and History* - This element is to be based on a physical examination by a physician where appropriate to or required by the

level of care. Otherwise the element will include the completion of a physical health screening by the clinician. It will include, but is not necessarily limited to, a medical history, a review of current medications, present or past significant illnesses, changes in weight, eating habits and/or sleep patterns, injuries, allergies, sexual activity and orientation if relevant, and family history of chronic illnesses.

g) *Behavioral Health and Treatment His*tory - This element includes a review of the history of treatment for mental health or substance abuse disorders and a chronological review of symptom manifestations. Reference to the CMH SAF when applicable fulfills this requirement.

h) *Client and Family Strengths and Cultures*- This element includes a current exploration of positive traits and characteristics of the client and family members upon which a treatment plan can be based. This may be referenced as part of the family assessment.

i) *Religious Beliefs and Practices* - This element includes the foundations of spirituality, beliefs and connection with religious congregations which may provide support for attainment of treatment goals, or be a protective factor where risk factors are present.

j) *Background Information*, as applicable, whichwill include but not necessarily be limited to:

- History of familial substance abuse or mental illness
- History of familial incarceration
- History of abuse or neglect

k) The *5-Axis DSM-IV Diagnosis* based on the content of the assessment components listed above. Deferred diagnoses are not acceptable.

D. Integrated Interpretive Assessment Summary (Admission Summary) - Timeframes for completion of this document for all levels of care are listed in the Deliverable Section of this Manual. For routine outpatient services, this document must be included in the client record within five working days after the third session.

An integrated interpretive assessment summary is a narrative synthesis of the data gathered from the initial assessment, and from collateral information obtained from schools and other sources such as the CMH Service Admission Form (SAF). This narrative is made of of sentences/paragraphs (Single words do not suffice.) It covers physical, psychological, psychiatric, social and spiritual domains. This summary is used to facilitate the identification of individual treatment requirements, strengths, and risks currently presented by the client. The integrated assessment is used to develop appropriate treatment interventions. This summary will be contained in the client record and will include but not necessarily be limited to:

1. A strength-based, behaviorally oriented, client focused, interpretive summary that consolidates the four primary dimensions of physical, psychological, social and spiritual findings into a single current clinical picture that will be used to create the treatment plan.

2. The interpretive summary specifies (1) issues which will be treated by the provider, (2) those that will be addressed by other providers and (3) those that will be deferred, with justification as to reasons for deferral.

3. Where applicable, the CMH Service Admission Form may be referenced. The provider will develop a treatment plan that is consistent with the information on the integrated/interpretive summary..

4. The initial treatment plan (and subsequent comprehensive treatment plans) will include contingency plans for all at-risk behaviors idenitifed on the assessment and/or by the CSM Team on the Service Admission Form.

E. Comprehensive Treatment Plan - This document is based on the integrated assessment and, where applicable, is consistent with the service plan contained on the CMH Service Admission Form. (SAF) It is done in conjunction with the client and family (as documented by their signatures), and where applicable, includes input from the CSMT. Elements of the treatment plan will include:

1. *Problem statements* will include, but not necessarily be limited to:

   a) Issues of serious risk, e.g. potential suicidality, homicidality, fire-setting, inappropriate sexual behavior and, as applicable, other risk factors listed on the CMH SAF.

   b) The presenting problem(s) for which the client was referred.

2. *Criteria for Discharge* – This element specifies how the client, family, therapist and where applicable the CMH CSMT, will know that treatment is completed.

3. *Treatment Goal* – This element is related to the problem statement and is an affirmative statement of the end-purpose of treatment, e.g. to reduce the use of suicidal threats as an expression of anger. These should reflect both the client's and family's goals for treatment that are realistic, e.g. client goal "get the P.O. off my case"; parent goal "get client back in school."

4. *Treatment Objectives* – This element is a more detailed, behaviorally specific, measurable and time-limited approach to goal achievement, e.g. Within the next 30 days, episodes of suicidal threats as expressions of anger will be reduced by half. Treatment objectives are changed and modified to reflect progress in treatment.

5. *Modalities of Treatment/Treatment Interventions* – choices of treatment modality and specific interventions should reflect approaches that have evidence in empirical literature to be effective for the problems for which the client is being treated.

   a) If medication is being prescribed as part of the treatment by the agency, this modality will be included in the treatment plan.

   b) If a wrap-around aide is being used to support the treatment plan, this intervention will be included in the treatment plan.

6. *Integrated Wrap-Aide Activity Plan* – Where treatment is being supplemented by a wrap-around aide whether or not the provider is employing the wrap aide, the wrap-aide activity plan must reference the treatment plan. In agencies that provide only the wrap service, a copy of the current treatment plan from the treating agency must be included in the record. .

7. *DSM*-IV 5-Axis Diagnosis – which can be substantiated in the comprehensive assessment as described in Sections C and D above.

8. Signatures and responsbilities of all members of the treatment team, including:

   a) Primary therapist

   b) Licensed practitioner/supervisor if primary therapist is not licensed.

   c) In Delaware substance abuse programs - LCDP/CADC, if the primary therapist is not certified in the treatment of substance abuse.

d) If the provider is a nonresidential program in which a psychiatrist is also providing treatment/medication monitoring, signature of the psychiatrist or nurse practitioner.

e) If the provider is a JCAHO accredited Residential Treatment Center (RTC) or psychiatric hospital, signature by physician.

f) Signature of the child (if over the age of six)

g) Signature of the parent/caretaker

F. Treatment Plan Review and Revision - As appropriate for the level of care, the treatment plan will be reviewed and revised whenever new goals and objectives are added; or when identified goals or objectives are accomplished; or no less often than every 90 days. If goals are added to the treatment plan or other significant changes are made, it is necessary for the provider to add pages to the plan or to write a new plan, depending on the agency format for this purpose. Significant treatment plan changes will be communicated with the CMH CSMT, where applicable.

G. Progress Notes - Progress notes are documentation of the services that have been provided. They will document all direct (face-to-face) services and indirect services. Failure to document services consistent with billing and activity reporting to the Division may result in an audit exception and resultant financial penalties.

1. Progress notes for direct service will document progress toward treatment goals and objectives, and will be appropriate to the level of care.

2. For services in which billing/activity is reported in units of hours, every specific billing code reported to the Division will have a separate progress note. The content of this note will be appropriate to the amount of time spent on the activity and will always relate to the treatment plan.

3. For service in which billing activity is reported in units of days, every specific day reported to the Division must have at least one progress note. Where individual, family and psychiatric sessions are provided in the course of a specific day, these will be separately documented.

4. Prpogress notes will be dated, signed by the therapist and specify the location of the service provided and all those participating.

G. Discharge

1. At a reasonable point in advance of discharge from any level of care, the provider will document that they have discussed follow-up treatment recommendations with the client and family and, where applicable, in collaboration with CMH CSMT. The provider will offer assistance in and/or provide information for the referral process to the next level of treatment, if applicable.

a) The provider determines in collaboration with the CSM where applicable, when the client no longer meets clinical necessity for the current level of care.

b) Where applicable, the CSM team, in conjunction with the provider, will plan for transition to adult services and CSM team will document efforts to implement this plan.

2. Within 15-days of discharge, the provider will complete a discharge summary, a copy of which will be retained in the client file. The discharge summary will be submitted to CMH as indicated in the "deliverables" section of this manual, and will be made available to subsequent treatment providers upon request and appropriate signed release. The discharge summary, which will be signed and dated by the primary therapist (co-signed by licensed clinician if the primary therapist is unlicensed) and will include, but not be limited to, the following elements:

a) Dates of treatment (admission to discharge)

b) Number of sessions or total days of treatment received

c) 5-Axis DSM-IV discharge diagnosis

d) Primary therapist name and signature

e) Summary of treatment, including name(s) of any consulting professional(s)

f) Participation of the client in the treatment process

g) Participation/involvement of the family in the treatment process

h) Unresolved treatment issues

i) Treatment recommendations, aftercare plans and referral assistance as applicable

3. Providers of routine outpatient services will send a Discharge Form to CMH within 30 days of the last direct face-to-face contact. If a client stops attending sessions and the therapist wishes to follow up to try to re-engage the client and family, this must be done within the 30-day timeframe. CMH clients may not simply be administratively discharged without follow-up attempts being documented. Notification of this discharge is done through the Outpatient Discharge Form available on the CMH Website.

H. Clinical Records The provider will maintain clinical records on all clients in accordance with accepted professional standards and practices. These will be completely and accurately documented, readily accessible, and systematically organized to facilitate prompt retrieval.

1. Completion of records – All clinical information pertaining to a client will be centraliized in the client record. This will include but not necessarily be limited to correspondence, consets and realeases, copies of collateral reports, etc.

a) The provider will have policies and procedures in place to assure that all clinical records, including those of discharged clients are completed promptly.

2. Storage and Security - The provider will assure that written, electronic and other records containing confidential client information will be accessible only to those individuals who have a right to the information.

3. Retention and Preservation - CMH providers are required to retain, in an easily accessible format, the entire clinical record of any CMH client for a minimum of five years and at least three years past the eighteenth birthday of the minor. Following the required period of retention, the provider will retain for an indefinite period, the discharge summary for each specific treatment episode.

VI. CLIENT SAFETY AND OUTCOME

A. Clinical Program

1. Staffing - All staff providing direct client services will practice within the scope of their qualifications, licensure or certification.

   a) Clinical Director - The provider will identify one of the following Delaware licensed behavioral health professionals to be responsible for the clinical program. This will include clinical supervision, where applicable.

      (1) Psychiatrist

      (2) Licensed Psychologist

      (3) Licensed Clinical Social Worker (LCSW)

      (4) Licensed Professional Counselor of Mental Health (LPCMH)

      (5) Licensed Marriage and Family Therapist (LMFT)

      (6) Substance abuse programs (only) may also be clinically directed by a Licensed Chemical Dependency Professional (LCDP)

   b) Psychiatric Services – The provider will have the capacity to provide medication evaluation and medication monitoring for clients on an as-needed basis in a volume consistent with average program utilization and clinical need, unless specifically exempted from this requirement by the contract.

      (1) Child Psychiatrist

      (2) General Psychiatrist - may treat adolescents age fourteen and older

      (3) Psych/MH Nurse Practitioner with national certification in child/adolescent mental health and with prescriptive authority

      (4) Psych/MH Clinical Nurse Specialist with national certification in child and adolescent mental health and with prescriptive authority.

2 Supervision – As appropriate to the level of care and the type of services (MH or SA), the provider will document consistent oversight/supervision for all employees who are providing direct treatment services. Documentation will include but not necessarily be limited to:

   a) Signature of a licensed practitioner on all initial assessments if performed by an unlicensed clinician. This signature indicates that the form and content is clinically appropriate, consistent with agency and CMH standards and assumes clinical responsibility for the treatment being provided.

   b) Signature of a CADC/LCDP on initial assessments in substance abuse programs. This signature indicates that the form and content is clinically appropriate, consistent with agency and CMH standards and assumes clinical responsibility for the treatment being provided.

c) Signature of a licensed practitioner on all treatment plans if developed by an unlicensed clinician. This signature indicates that the form and content is clinically appropriate, consistent with agency and CMH standards and assumes clinical responsibility for the treatment being provided.

d) Signature of a CADC/LCDP on all treatment plans in substance abuse programs. This signature indicates that the form and content is clinically appropriate, consistent with agency and CMH standards and assumes clinical responsibility for the treatment being provided.

e) Case specific supervision notes indicating that the supervisor and the supervisee have discussed the case periodically and decided on a course of action to be taken. Where supervisory recommendations have been made, there should be documentation that the recommended actions have been taken. (This follow-up documentation may be in the form of a modified treatment plan, progress note or supervisory note.)

f) Unlicensed clinical staff providing direct treatment services must document, at minimum, one hour per week of supervision.

g) The provider will document that the work of licensed treatment staff and/or licensed supervisory staff is reviewed. This may be in the form of Peer Review or Quality Improvement Review. The purpose of this review is to assure that every clinician is held accountable to comply with agency and CMH standards.

B. Performance Improvement - CMH is committed to the provision of safe appropriate services that facilitate positive behavioral change and positive outcomes for clients and their families. Providers will use a continuous performance improvement process that will achieve these outcomes.

1. The provider will have and implement a detailed written performance and quality improvement plan which establishes a process for ongoing monitoring and evaluation of the quality and effectiveness of treatment and client safety.

a) The plan and resulting process will assure that there is clinical oversight of services provided by all staff.

b) Where licensed staff are otherwise operating without clinical supervision, there will be a process by which the quality of their work is reviewed. This may be through peer-review, QI Committee review, etc.

2. This plan and related procedures will start with data/information. Design and implementation of improvements will be tracked and data will be gathered to assess whether the improvements achieved the desired outcomes.

C. Outcome Measurement - CMH conducts empirical measurement of client outcomes both at the individual client level and at the systems level.

1. Client Progress Reviews - The Clinical Services Management Teams initiate client Progress Reviews to evaluate client progress periodically throughout treatment and at discharge. Providers will insure that staff is reasonably available for these reviews and that accurate and complete information as to progress in treatment is provided.

2. Pre- and Post-Measurement and Data Submission - The provider will cooperate with CMH in administering reasonable pre- and post-treatment outcome measurement instruments, and reporting on a quarterly basis reasonable requests for data on approved CMH forms or systems.

D. Client Rights and Responsibilities

1. The Provider will have policies and procedures addressing clients' rights and responsibilities. These policies will conform to the CMH policy on rights and responsibilities. Documentation that clients have been informed of these rights in a language they can understand will be contained in the client record.

2. CMH will make available to providers copies of the CMH Handbook for Child/Family Entering Care. The provider will maintain copies at sites where CMH clients are served so that they are accessible to clients upon request.

E. Confidentiality

1. *General Requirements* - The provider will have written policies and procedures to assure that staff comply with state and federal laws and with appropriate professional practice regarding the handling of confidential client information, including release of information. These policies and procedures will specify the condition under which client information will be disclosed and the procedures for releasing such information. All CMH providers will follow DSCYF (No. 205) and CMH (CS002) and will be in compliance with HIPAA 45 CFR. Policies on Confidentiality are available on the Department and Division web sites. Releases will be time-limited for periods not to exceed one year and have specific beginning and ending dates.

2. *Substance Abuse* -Written policies and procedures shall specify how confidentiality relates to the clients receiving substance abuse treatment. All statements of confidentiality, releases and client rights must include reference to the Federal confidentiality standards sited in 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and will also be in compliance with HIPAA 45 CFR.

F. Complaints - Clients and providers have the right to address grievances and complaints to CMH. Please note that at anytime Medicaid clients may lodge a complaint with the Medicaid Office, the Health Benefits Manager or request a Fair Hearing process (see CMH Handbook for Client/Family Entering Care).

1. *Complaints about CMH* - The CMH complaint policy ensures an accessible and fair process for resolving the concerns of providers and clients, their parents, relative caregivers, guardians, custodians, or their authorized representatives. It is the intent of CMH to resolve concerns without the use of formal processes where possible. However, if a concern cannot be resolved to the satisfaction of the aggrieved individual or entity, they may file a complaint with the appropriate CMH Unit Director.

2. *Complaints about CMH Providers* - Family or client complaints about CMH service providers should always be addressed first to the service provider. If a CMH staff member is notified of a complaint about a provider, the CMH staff will direct the aggrieved individual to the appropriate person at the provider organization. In addition, a CMH System Administrator may also address the complaint with the provider, depending on the circumstances. If the complainant is not satisfied with the provider's response, the complainant may contact the CMH System Administrator assigned to the program.

3. The Quality Improvement Unit, (302) 892-6432, is available to assist in the complaint process.

G. Risk Management

1. *Risk Management System* - The provider will have an overall risk management system as well as procedures for developing individual client risk management plans which includes procedures for assuring client safety.

2. *After-Hours Clinical Emergencies* - The provider will have 24-hour, 7 day/week on-call coverage for active clients. Services performed by on-call coverage are subject to the same clinical standards as those of the contracted provider.

   a) The provider will give active clients and families clear written directions for how to reach the provider in an after-hours emergency. The provider will document that clients have been given this information with a signed form that will be filed in the client record.

   b) For all nonresidential programs, recorded telephone messages will include the CMH crisis number(s).

   c) If the provider has an active client who may be in danger of going into crisis during periods when the client is not receiving direct services, the provider will:

      (1) Remind the client and family about the provider's crisis procedures.

      (2) Provide the appropriate CMH Crisis Services number to the client and primary caretaker.

      (3) With parental consent, provide for the notification of the appropriate CMH Crisis Services team about the client, current clinical status, and instructions for how to reach the provider if a crisis occurs.

      (4) If a client is active with CMH Crisis Services, work with them to reach disposition of clients in crisis.

H. Critical Incidents

1. *General Requirements* - All DSCYF providers are required to follow the procedures as listed in the DSCYF Operating Guidelines. These procedures are further articulated in the CMH Incident Reporting Policy and Procedure that is found at the following Internet site: http://kids.delaware.gov/pdfs/pro_cmh_pi002_2007.pdf. Written reports are to be faxed to the CMH Quality Improvement Administrator at E-Fax 1-302-661-7270. The form for this report is located on the CMH Provider Website.

2. *Alleged Child Abuse* - For any allegation of child abuse:

   a) *If the CMH provider delivers services in Delaware* - The Provider recognizes that its employees and therapists are mandated reporters as specified in Title 16, Delaware Code, Chapter 9, Paragraphs 901-909. The provider shall assure that its entire staff who provide services under this Contract are trained in DFS reporting procedures. When a provider's employee or agent knows or reasonably suspects child abuse or neglect, including any such incident within the agency, or receives a complaint of same from a client receiving services by the provider, then he/she shall make an oral report to the Delaware Child Abuse Report Line by calling 1-800-292-9582. Within 72 hours of the oral report, a completed Child Abuse Reporting Form shall be sent to the appropriate regional office of the Division of Family Services. At the same time, a copy of this report must be forwarded to a CMH Quality Improvement Administrator.

      - For further information about professional responsibility with regard to abuse and neglect, consult http://kids.delaware.gov/information/cai.shtml to read "The Professional's Guide to Reporting Abuse and Neglect."

b) *If the provider does not deliver services in Delaware* - The provider shall adhere to the guidelines for critical incident reporting set forth in the CMH policy. Additionally, the provider shall follow the legal requirements for reporting child abuse and neglect in the State in which services are provided. A copy of this report must be forwarded to the CMH Quality Improvement Administrator. (See CMH Website)

⇒ CMH Quality Improvement Administrator Fax 1-302-661-7270.

I. Environment and Milieu

1. Emergency Preparedness - The provider will have and implement a written plan for natural and man-made emergencies, including but not limited to fire, weather emergencies, criminal and/or terroristic acts. Fire safety plan will comply with the National Fire Protection Association Life Safety Code. It will also comply with the DSCYF Operating Guidelines regarding client safety. At minimum, these procedures will list evacuation and shelter-in-place/lockdown procedures as appropriate to the level of care.

   a) Drills for evacuation procedures will be documented as having occurred, at minimum, once per year on every shift at every location, as applicable to the level of care.

   b) Drills for lock-down/shelter-in- place will be documented as having occurred, at minimum, once per year on every shift, at every location, as applicable to the level of care.

   c) Table-top exercises involving all pertinent staff may replace *in vivo* drills if they are appropriate to the level of care.

   d) Documentation for drills will include at minimum, date, time, purpose, participants, outcome summary, and lessons learned, if applicable.

2. Smoking - Smoking is not permitted by any minor in any state operated or funded facility or program. Smoking by adults will be permitted only in designated areas which are away from space used in common for therapeutic and living activities and recreation as well as being out of sight of the children. Under no circumstances will the purchase of tobacco products by minors be directly or indirectly supported by program personnel.

3. Hazardous Materials - If applicable to the treatment setting, the provider will establish and maintain a program to safely control and dispose of hazardous or potentially infectious materials and waste.

4. Medication - The provider will have policies and procedures for prescribing, transporting, dispensing, administering and/or ordering medications, as applicable. These policies and procedures will address, at minimum, procurement, storage, control and documentation thereof of all medication in accordance with rules and regulations of the State Board of Pharmacy, the State Board of Nursing, Delacare and other authorizing agencies as applicable.

5. Other Medical Expenses - CMH is not responsible for medical/dental costs for clients in authorized residential treatment. Providers of 24-hour facilities are responsible for ensuring that clients receive necessary medical and dental care. CMH will supply Medicaid numbers for all youth in programming for 30 days or longer. It is the responsibility of all providers to encourage their local healthcare providers to enroll in the Delaware Medicaid program if they wish to avoid assuming the costs of routine medical care that is provided by external health care entities and not covered by private health insurance.

6. Behavior Management/Seclusion/Restraint (Only for hospital, residential and related day treatment programs which are licensed and/or JCAHO-accredited.) These providers will have policies and procedures in place for the safe and appropriate use of restrictive behavior management techniques such as seclusion and restraint.

    a) Staff in community-based programs, e.g. crisis, outpatient, wraparound, intensive outpatient, may not restrain clients. This should be reflected in policy and procedure for providers of these levels of care, and all staff must know about this limitation.

I. Program Review - CMH performs program reviews, which may include but not be limited to: desk audits of available data on utilization and outcome, accreditation and licensure status, complaints, incident reporting and deliverable submissions, etc. Periodically, CMH also conducts on-site monitoring surveys to evaluate client safety, appropriateness of services and compliance with DSCYF and CMH standards in accordance with the Contract Statement of Agreement, Article V, Paragraph I.

VII. DOCUMENT DELIVERABLES - See the schedules of deliverables for specific requirements.

A. Clinical Reports

1. Requirements - Each provider will send copies of client-specific clinical reports to CMH. These include, but are not limited to admission summaries, treatment plans and discharge summaries. See the schedule of clinical documentation deliverables that follow for specific requirements.

2. Document Submission - The required clinical reports will be sent or faxed to the CMH regional clinical services office indicated on the service admission form (new clients), or regional office where the client's CMH Clinical Services Management Team is located, Attention: CMH Records Technician. Fax numbers for these are avaiaible on the CMh provider website. (Scroll to the bottom of the page.)

B. Client Safety Documents

1. Incident Reports - Copies of critical incident reports to CMH as directed by and on forms specified in the DSCYF Operating Guidelines. This is pursuant to CMH Incident Reporting Policy (PI002).

⇒ Fax copy of incident reports to Quality Services Administrator at E-fax at 1-302-661-7270 within 72-hours of the incident.

⇒ Abuse/Neglect Reports – by out of state providers to their state regulatory authority. See VI, G. 2.

C. Credentialing - CMH is committed to meeting the highest standards in quality client care. It is therefore expected that all CMH employees and network providers will possess the necessary education, skills, and training to fulfill their job responsibilities in a competent manner.

1. Providers will comply with CMH Policy HR 001 and the related procedures.

2. Human Resources Forms (HR Forms and Directions available on the CMH Website) will be submitted to the respective CMH systems administrator for all staff who are providing treatment services or who are supervising staff who are providing services under contract or agreement with CMH as follows:

a) Hospitals and day hospital programs in Delaware and outside of Delaware residential treatment programs and hospitals - The CMH systems administrator responsible for the contract will contact the organization to obtain information that is needed for the HR form. Information will be required on the attending physician and/or the licensed practitioner who is clinically responsible for the client being served.

b) Delaware residential treatment and related day treatment programs - Submit an HR form on all licensed practitioners providing treatment to clients.

c) Free standing day treatment and part-day programs - Submit HR forms for all staff that see clients or supervise the treatment provided.

d) Intensive outpatient programs - Submit HR forms for all staff that see clients or supervise the treatment provided.

e) Crisis programs - Submit HR forms for all staff that see clients or supervise the treatment provided.

f) Outpatient programs - Submit HR forms for all staff that see clients or supervise the treatment provided.

g) Wrap-around programs - Submit HR forms for all staff that see clients or supervise the treatment provided.

h) Urgent response and early intervention - Submit HR forms for all staff that see clients or supervise the treatment provided.

3. Independent licensed practitioners who provide services in agencies and/or organizations not having accreditation status as described in Part I of this manual must be credentialed under the CMH Credentialing Committee. Directions and application forms are available on the CMH website for providers.

SCHEDULE OF DOCUMENT DELIVERABLES - CLINICAL INFORMATION

# Days Post Admission Rec'd by CMH	CLINICAL DOCUMENTATION TO BE SENT TO CMH	Reference	ACUTE CARE PROGRAMS		NON-ACUTE CARE PROGRAMS			
			Crisis	Hosp	RTC **	Day	IOP	Wrap
5	Provider Certificate of Need Form	IV.C.1.a)(3)		•				
5	Admission Summary - with physician signature	V.D.		•				
7	Admission Summary - with signature of licensed independent practitioner (JCAHO RTC's must have physician signature)	V.D.			•	•	•	
2	Completion of Contact Information in FACTS	V.F.	•					
16	Comprehensive Treatment Plan (Wrap-Activity Plan)	V.F.		•	•	•	•	•
18 Days after discharge	Discharge Summary	V.H.	•	•	•	•	•	•

** Note: RTC includes all residential treatment, including individualized residential treatment (IRT) and therapeutic group care.

ROUTINE OUTPATIENT SERVICES ONLY

DOCUMENT	OUTPATIENT DOCUMENTATION TO BE SENT TO DCMHS	Reference	Received at DCMHS
Initial Request for Service Authorization	Admission to Mental Health or Substance Abuse Outpatient Services	IV.C.2.a)	Immediately after 1st Session
Request for Continued Service Authorization	Revised/current Treatment Plan Request for Re-authorization	IV.C.2.b)	By Expiration Date or by use of last units authorized
Discharge	Discharge Form	IV.C.2.b)(3)	Within 18 days after discharge

SCHEDULE OF DOCUMENT DELIVERABLES - ADMINISTRATIVE INFORMATION

ADMINISTRATIVE DOCUMENTATION	Reference	SUBMISSION TO:
Incident Reports	DSCYF Operating Guidelines	Quality Services Administrator at E-fax 1-302-661-7270 within 72-hours of the incident.
Credentialing of Therapists Providing Direct Treatment or Acting as Supervisor of Staff Providing Direct Treatment (Note: This applies only to contracted providers. Obtaining a contract with CMh must precede the credentialing process.)	VII. C	Submit credentialing applications: Chair, Credentialing Committee Division of Child Mental Health 1825 Faulkland Road Wilmington, Delaware 19805
Annual Provider Documentation • Business License, if applicable • Insurance: Proof of commercial liability and motor vehicle insurance as applicable • Licenses as applicable • Most recent accreditation letter and certificate • Providers' contract manager information • Provider's contact for billing and authorization • Provider's Remittance Address • Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business • Documentation or assurance that the Provider's teachers are qualified to serve students with disabilities in the State in which the Provider does business If these are checked on the DSCYF Document Checklist) • DSCYF Rate Certification Form • DSCYF HCFA Sanctions Certification Form • Copy of Agency Operating License(s) • Criteria for Provision of Inpatient Psych Services for Individuals under Age 21.	DSCYF Document Checklist *Enclosed Annually with Contract*	Submit annually with the signed contract to: DSCYF Contract Administrator 4417 Lancaster Pike Building #18 Room 2158 Wilmington, Delaware 19805

VIII. REIMBURSEMENT - CMH makes every effort to process bills and authorize reimbursement so that payment may be obtained in less than the thirty days stipulated in the contracts. If, however, the Provider submits bills which are inaccurate, illegible, are for unauthorized services, have calculation errors or are otherwise problematic, CMH will not accept responsibility for delayed and/or reduced payments.

Providers must submit bills in a timely fashion. Late bills which exceed 12 months from the time the service was rendered will be honored *only* if funds exist in the current State fiscal year to pay them.

In the case of electronic billing, providers will be unable to enter any claim which is not authorized. *Reimbursement may be contingent upon receipt of all contract deliverables due at the time invoices are submitted.*

⇒ **Mail all bills and activity logs to Data Unit, Division of Child Mental Health Services, 1825 Faulkland Road, Wilmington, Delaware 19805**

A. Submission of Hardcopy Billing

1. Cost-reimbursable Contracts and State Operated Programs - RTC's, day treatment, intensive outpatient, crisis intervention, crisis bed, urgent response
   a) Activity logs and/or calendar logs must be submitted monthly directly to the CMH Data Unit no later than the 15th of the next month.
   b) Line item bills from cost-reimbursable programs will be submitted monthly and contain at minimum:
      Column # 1 - Annual contracted budget by line-item with total.
      Column # 2 - Current-month expenditures by line-item with total.
      Column # 3 - Total billed to date by line item with total.

2. Unit Cost Contracts (Per hour, Per diem)
   a) Nonresesidential programs (Intensive outpatient, outpatient and wrap-around services) - Bills will be submitted on Standard Individual CMH Non-Residential Billing Forms with a standard Billing Summary Sheet at the face of each package of client billing forms. All information must be completed, e.g., dates of authorization, diagnosis.

   b) All Other Unit-Cost Contracts - At minimum, bills must contain:
      - Client name
      - Client date of birth
      - Admission date
      - Each date billed in that month on which units of service were provided and for which the unit cost is being charged, along with a subtotal for each client.
      - Provider of the service (primary therapist)
      - Dates of authorization and the authorization number
      - DSM-IV diagnosis
      - Cover sheet with total being billed for the program/service level

   c) Bills for each level of service must be submitted separately

B. Submission of Electronic Billing - Please refer to the CMH Electronic Billing Procedure for detailed instructions on how to use electronic billing. Providers must be trained prior to participation in electronic billing. Contact CMH FACTS Liaison, (302) 892-6442 to inquire about the training.

1. It is the responsibility of all providers participating in electronic billing to notify CMH within one working day of a client's admission and diagnosis.
2. All providers must also complete any billing/activity data entry by entering their data into FACTS no later than 4:30 PM on the tenth working day of the month following the close of the month being billed. Bills not entered by 4:30 PM on the tenth working day of the month will be submitted in the next month's bill.
3. Providers do not have to submit a hardcopy bill if participating in electronic billing.

⇒ Technical questions about electronic billing can be addressed by contacting the CMH FACTS Liaison at (302) 892-6442

⇒ Financial questions about electronic billing can be addressed by contacting the CMH Data Unit at (302) 892-6464

C. Direct Deposit - DSCYF offers direct deposit for vendor checks. To find out more about the direct deposit option or to enroll call Patricia Lisinski at 302-892-4533. Participating vendor feedback has been positive and the system has been operating smoothly since October 2002. Electronic payment benefits cited include quicker receipt of payment, elimination of lost checks in the US mail service and time saved on payment questions.

IX. FEEDBACK AND SUGGESTIONS

This manual is updated regularly as requirements are added or changed. CMH welcomes feedback and suggestions for improvement from propviders and the public at large. Please direct any questions or comments to:

Jeanne A. Dunn, Non-Residential Services Administrator
Division of Child Mental Health Services
1825 Faulkland Road
Wilmington, Delaware 19805

(302) 633-2593
jeanne.dunn@state.de.us

NOTE:

Any references to DSCYF and CMH policies and procedures, and/or forms for various purposes can be found on the DSCYF Website. http://kids.delaware.gov/

Necessary Forms, e.g. Billing, Outpatient Admission and Discharge Forms, Human Resources Forms and Credentialing Applications can be found on the DCMHS website in the special section for providers. http://kids.delaware.gov/cmhs/cmhs_providers.shtml